Medical Staff Conference

Issues in Latino Health Care

These discussions are selected from the weekly staff conferences in the Department of Medicine, University of California, San Francisco. Taken from transcriptions, they are prepared by Drs Homer A. Boushey, Associate Professor of Medicine, and David G. Warnock, Associate Professor of Medicine, under the direction of Dr Lloyd H. Smith, Jr, Professor of Medicine and Associate Dean in the School of Medicine. Requests for reprints should be sent to the Department of Medicine, University of California, San Francisco, School of Medicine, San Francisco, CA 94143.

RICHARD K. ROOT, MD:* *Persons of Latino background are making up an increasing percentage of Americans in many areas of the United States. In this timely review, Eliseo Pérez-Stable, MD, Assistant Professor of Medicine at the University of California, San Francisco (UCSF), School of Medicine, illuminates cultural issues that can have an important effect on the physician-patient relationship and on the institution of broader health care programs for Latinos. Dr Pérez-Stable was born in Cuba and immigrated to this country in 1960. He has BS and MD degrees from the University of Miami and received his training in primary care internal medicine at UCSF. He was the recipient of the Henry J. Kaiser Foundation Fellowship in General Internal Medicine and joined the faculty at UCSF in 1981. Besides his role as an excellent clinician and teacher, Dr Pérez-Stable is Director of the Primary Care Internal Medicine Residency Program at UCSF and is supported by two grants from the National Institutes of Health to study and develop effective programs on smoking cessation intervention in Hispanics and the treatment of mild hypertension.*

ELISEO PÉREZ-STABLE, MD:† In this Medical Staff Conference I will present an overall picture of Latino health care issues from a multidisciplinary perspective. First, I will review the demographic profile of Latinos in the United States. Next I will summarize pertinent health care access issues and focus on three specific topics—cardiovascular risk factors, tuberculosis and depression. Finally, I will discuss the concept of cultural barriers to medical care from a Latino perspective.

The cultural and historical roots of Latinos are found in the Iberian Peninsula, in the highly developed indigenous societies of pre-Columbian America and in western and southern Africa. Spain was the dominant colonial power in Latin America, and thus the designation "Hispanics" as a label for Latinos in the United States is not fully acceptable. Hispanic is the official name used by the federal government, but use of this term implies a heritage restricted to Spain. Latino is Spanish for Latin, but it is the prefix attached to the American continent south of the Rio Grande (*Latino* America). Thus, the name Latino reflects the integration of Spanish, indigenous and African cultures that are part of our identity. I prefer to use Latino as a generic label as, for example, does the American Public Health Association. The use of names such as "Chicano" or "Raza" reflects the emergence of ethnic pride among second-generation Mexican-Americans, and these may not be acceptable to recent immigrants or to persons from other subgroups. Other terms such as Spanish or Latin should not be used.

Latinos come from many different countries and each one has a distinct national culture. Whenever possible, the country of origin should be identified and the proper name used in referring to patients, such as Mexican, Salvadorean and so forth. In the United States Latinos share a common language and cultural heritage and, in general, these similarities predominate over national differences.

Demographic Profile

The United States has the sixth largest "Hispanic" population in the world, exceeded only by Mexico, Spain, Colombia, Argentina and Peru. According to the official US census, between 1970 and 1980 there was a 61% increase in the Latino population in the United States from 9.1 to 14.6 million persons.[1] Including estimates of uncounted, undocumented persons and adjusting for growth since 1980, there are probably more than 20 million Latinos, or 8% of the total population in the United States.[2] Demographic projections buttress the contention that Latinos may become the largest minority group in the United States by the year 2000.

Latinos of Mexican origin are the largest subgroup with 59.8% of the total, followed by Puerto Ricans (13.8%) and Cubans (5.5%).[1] The category of "other Hispanics" comprised 20.9% of US Latinos in 1980, and this may now actually be greater as a result of the recent influx of immigrants from Central America. Most Latinos live in urban areas (87%), and 82.9% are concentrated in eight states, with California and Texas containing 51.6% of the total. In 1980 nearly a third of Latinos were foreign-born and approximately a quarter spoke little or no English.[1]

In California 20% of the population is Latino and most are of Mexican origin. Los Angeles and San Jose have the largest proportion of Latinos, who make up nearly 30% of their populations. In San Francisco, Latinos of the "other Hispanic" category outnumber those of Mexican origin.[3]

Health Care Access and Health Care Status

National data from the Health Interview Surveys (HIS) conducted by the National Center for Health Statistics be-

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ABBREVIATIONS USED IN TEXT

HDL = high-density lipoprotein
HHANES = Hispanic Health and Nutrition Examination Survey
HIS = Health Interview Surveys
UCSF = University of California, San Francisco

tween 1978 and 1980 have been analyzed for persons self-identified as Latinos. In general, Latinos made physician visits as frequently as did Anglos (whites not of Latino origin) or blacks, but subgroup differences were present. Mexican-Americans average 4.3 physician visits per person per year, which is significantly lower than the average for Anglos (4.8), blacks (4.8) or other Latinos (5.1 to 6.1).[4] In addition, only a third of Latinos, compared with half of Anglos, made at least one annual visit to a dentist.

Latinos are less likely than any other ethnic group to have any form of medical insurance. A national phone survey by the Robert Wood Johnson Foundation found that 18% of Latino adults lack any insurance or were refused care for financial reasons, which compares with 8.5% of Anglos and 13.4% of blacks.[5] The HIS data show that Puerto Ricans and Cuban-Americans are twice as likely and Mexican-Americans three times as likely as Anglos to be without health insurance.[4] Another survey that included an adequate sample of Latinos in the southwestern states reported that a third lacked any form of medical insurance, compared with 11% of the general population.[6]

These studies indicate that access to health care is not as readily available to Mexican-Americans as it is for the general population. Access does not appear to be a problem among Puerto Ricans and Cubans. Significant economic barriers to adequate health care persist for Latinos, however, especially among the undocumented. Despite the differences in access and health insurance coverage, regional data indicate that Latinos may have a lower age-adjusted mortality rate for the three leading causes of death in the United States.[7] National mortality rates for Latinos, however, are not yet available, and further evaluation of existing data sources is necessary before generalizations can be made.

Even though Latinos may have a lower mortality rate than the general population, the epidemiology of homicide in Los Angeles County reveals a worrisome trend. Death by homicide is 2.3 times more likely in Latinos than in Anglos, and there was a 166% increase in Latino homicides between 1970 and 1979.[8] Alcohol was present in 57% of all tested Latino victims compared with 48% of blacks and 35% of Anglos. These findings may reflect an important social problem that has escaped the attention of the Latino community.

Cardiovascular Risk Factors

Hypertension

An elevated arterial pressure is a major cardiovascular risk factor that may be related to several life-style factors including social and environmental stress. Latinos in the United States have a socioeconomic status that is intermediate between Anglos and blacks, but, in addition, Latinos confront the stress inherent in migration and heightened by the language barrier. Although there is little known about dietary salt intake in Latinos, obesity is more prevalent than in Anglos. Thus it is reasonable to hypothesize that Latinos will have a greater prevalence of hypertension than Anglo-Americans.

The Laredo Project in Texas reported on the prevalence of cardiovascular risk factors in a population-based sample of 389 Mexican-Americans.[9] The prevalence of an elevated diastolic blood pressure (95 mm of mercury or higher) was found at a rate between that reported for Anglos and blacks in the Hypertension Detection and Follow-Up Program. The statewide California survey, however, which included 1,764 Latinos, showed that a diastolic blood pressure of 90 mm of mercury or higher or a systolic blood pressure of 140 mm of mercury or higher was present in 21.5% of Latinos.[10] This rate was not significantly different from Anglos (23.4%) or Asians (20%) and lower than the prevalence found in blacks (35.2%).[10] More recently, a report from the San Antonio Heart Study found an overall age-adjusted prevalence of hypertension for Mexican-Americans that was similar to or lower than that for Anglos of the same socioeconomic status.[11]

Surveys of hypertension in other Latino subgroups have been limited to children and adolescents. In Dade County (Miami), a hypertension screening program among 24,536 junior high school students between 1979 and 1981 reported that male Cuban adolescents had a higher prevalence of elevated blood pressure than did both Anglos and blacks.[12] No significant differences were observed among female adolescents. In New York, the "Know Your Body Study" reported a significantly higher blood pressure in 346 Puerto Rican children than in a comparison group of Anglo children.[13]

The Hispanic Health and Nutrition Examination Survey (HHANES) conducted between 1982 and 1984 was a comprehensive evaluation of the health status of more than 9,000 Latinos representative of the three major subgroups. Results from the Mexican-American sample have been analyzed, showing a lower prevalence of hypertension (16.8% for men, 14.2% for women) than in other national surveys of Anglos and blacks.[14] Comparisons among the three subgroups will be possible in the near future. If true subgroup differences exist, the greater African influence in Puerto Rico and Cuba may partly account for this.

In summary, current studies indicate that the prevalence of hypertension in Latinos may actually be lower than in other ethnic groups. Mexican-Americans, however, lag behind Anglos of similar socioeconomic status in their level of treatment and degree of control.[11] Preliminary results from HHANES show that 53.9% of Mexican-Americans are aware, 39.8% receive treatment and 19.4% are adequately controlled.[14] This compares somewhat unfavorably with other Americans who average 65% to 90% awareness, 50% to 75% under treatment and 30% to 50% in control (Table 1).[10,11,15]

TABLE 1.—*Summary of Cardiovascular Risk Factors in Latinos*

Risk Factor	*Comparison With General US Population*
Hypertension	Lower overall prevalence in adults; less awareness, treatment, control
Cigarette smoking	More men smoke, fewer women smoke
Lipids	Higher triglycerides, lower HDL cholesterol levels, total cholesterol similar
Diabetes mellitus	Non-insulin-dependent type is three times more likely in Mexican-Americans
Obesity	Greater overall prevalence, women more likely than men

HDL = high-density lipoprotein

Cigarette Smoking

Regional and national surveys of smoking behavior in Latinos have until recently reported a lower prevalence of current smokers when compared with other Americans. Evaluation of sex differences in Latino smoking behavior shows that the rate for women is consistently lower than that for Anglo and black women.[16] The smoking rate for Latino men, however, is now higher than for Anglo men and comparable to the rate for black men.[16] Marcus and Crane examined the 1979-1980 Health Interview Survey Latino sample[16] and found no variation in the male-female differences in smoking behavior by country of origin. The HHANES results show that 43% of Mexican-American men currently smoke cigarettes,[17] compared with 38% of Anglos and 45% of blacks in the 1980 HIS. Conversely, Mexican-American women reported a 24% prevalence of smoking in the HHANES study, less than the 30% for Anglo and black women in recent surveys. An increasing level of acculturation was associated with cigarette smoking among Latino women but not among men.

Although their proportion of smokers may be increasing, Latinos have consistently reported smoking fewer cigarettes per day than Anglos or Blacks.[16] For example, 41% of smoking Mexican-American men report smoking less than ten cigarettes per day, which compares with 9.6% of Anglo and 17.5% of black men.[17] If this self-reported behavior is confirmed by biochemical measures, and Latinos are in fact light smokers, then community-based cessation programs may have a greater chance for success.

Obesity

Obesity, defined as 120% or greater of "desirable weight," is more prevalent among Latinos of Mexican background. Population-based studies in Texas and California have reported that about 45% of Mexican-American women are overweight compared with 29% of Anglo and 35% of black women.[18,19] Latino men also have a greater average weight than Anglo men, but the differences are less striking. Although dietary and other life-style habits contribute to the greater prevalence of obesity in Latinos, there are additional cultural factors involved. In a survey from Texas, Latinos of both sexes tend to agree with the statement that "Americans are too concerned about weight loss," implying that the Anglo cultural ideal of "leanness" has not been fully accepted by Latinos.[20]

Lipids

Data from the San Antonio Heart Study have shown that Mexican-Americans in Texas carry a profile of "obesity related" cardiovascular risk factors.[21] These risk factors include a higher prevalence of obesity, glucose intolerance and lipid profile abnormalities. Elevated serum triglycerides and lower high-density-lipoprotein (HDL)-cholesterol levels are noted at a younger age in Texas Latinos than in comparable groups of Anglos.[21] Total serum cholesterol levels, however, have not been found to differ significantly from those in Anglos in regional studies.[21] The HHANES results indicate that nearly 29% of Mexican-American adults have moderate to high risk levels of serum cholesterol (greater than 240 mg per dl), which is similar to the proportion found in the general US population.[22]

Changes in dietary habits as a result of acculturation and a rising socioeconomic status may alter these risk factors. Mexican-American women living in the San Antonio suburbs have significantly lower levels of serum triglyceride and higher levels of HDL cholesterol when compared with age-matched women living in a barrio.[21] In contrast, Mexican-American men have increases in the total and low-density-lipoprotein-cholesterol levels with rising socioeconomic status.[21]

Diabetes Mellitus

The most important difference in cardiovascular risk factors between Mexican-Americans and Anglos is the prevalence of impaired glucose tolerance. Non-insulin-dependent diabetes mellitus is three times more prevalent among Mexican-Americans than among Anglos. The initial report from the Laredo Project indicated that Mexican-American men and women have a 10% to 11% prevalence of fasting hyperglycemia (greater than 140 mg per dl) compared with 4% for Anglo subjects in HANES I.[19] The San Antonio Heart Study has substantiated these data by using glucose tolerance tests and standard diagnostic criteria developed by the National Diabetes Data Group.[21] A rising socioeconomic status in Mexican-Americans from the barrio sample to the suburbs sample is paralleled by a decreasing prevalence of diabetes to the point that differences from the Anglo population disappear.[21]

Additional evidence that diabetes is a major health problem in Mexican-Americans comes from evaluating its major complications. In the state of Texas there is a sixfold increased risk of end-stage renal disease due to diabetic nephropathy among Mexican-Americans compared with Anglos and blacks.[23] The risk of any retinopathy was found to be three times more common in Mexican-Americans when compared with Anglos in a sample of patients with diabetes from the San Antonio Heart Study.[24] Diabetes may not only be more prevalent in Mexican-Americans, but it may also manifest more severe complications.

The higher prevalence of obesity among Mexican-Americans does not fully explain the greater risk of diabetes. Stern and colleagues stratified a population-based sample according to body weight and found a higher prevalence of diabetes among Mexican-Americans for each weight and sex category when compared with Anglo-Americans.[25] One possible explanation may be the genetic influence of the indigenous American peoples reflected in Mexicans but not in Anglos or blacks.[26] Comparison studies with other Latino subgroups in the United States will help address this question.

Tuberculosis

Immigrants from countries with a high prevalence of tuberculosis are expected to have an increased risk of entering the United States with active disease or of tuberculosis developing while they are residing here. Officially reported case rates from Latino America generally underestimate the true prevalence of tuberculosis by a factor of two to five. Control of tuberculosis comparable to that in the United States (1984 case rate = 9.4/100,000), however, has been achieved in both Cuba (1982 case rate = 8.3/100,000)[27] and Puerto Rico (1984 case rate = 12.8/100,000).[28] Mexico and the Central American countries have case rates of tuberculosis that are between 35 and 90 per 100,000 population.[29] These are four to ten times greater than the 1984 case rate for the US population.[28] The fact that so many Latino immigrants from Mexico and Central America enter the United States without docu-

ments means that there is no systematic screening program for tuberculosis. Thus the potential exists for tuberculosis to become a major health problem among Latinos in the United States.

The case rate of tuberculosis in US Latinos is estimated at 16.2/100,000 population for 1984.[28] This translates to an overall relative risk of 1.7 in comparison to the general population, but tuberculosis may be of special importance in Latino children. In 1984, of all reported cases of tuberculosis in persons younger than 5 years of age, 26.5% occurred in Latinos.[28] A review of 330 pediatric charts at a community health center in San Francisco between 1978 and 1983 found a 30% prevalence of positive tuberculin tests, an 11% overall rate of tuberculin conversions and five cases of active tuberculosis.[30] The conversion of tuberculin tests from negative to positive in US Latino-born children may indicate the presence of unsuspected transmission of tuberculosis.

A community-based survey of 1,879 Mexican, Central American and US-born Latinos was conducted by the San Francisco Division of Tuberculosis Control in 1983-1984. The overall rate of positive tests was 37%, with birthplace outside of this country and age the most important predictors of tuberculin reactivity (Figure 1).[31] Even among US-born Latino children younger than 5 years of age, rates of positive tests were 2%, exceeding the recommended threshold for routine screening of population groups.[32] Neither history of vaccination with the bacillus Calmette-Guérin or duration of time residing in the US among the foreign-born influenced the rate of positive tests. Based on these data, tuberculosis screening and prevention activities should be a priority in meeting the health care needs of Latino immigrants from Mexico and Central America.

Although the magnitude of the tuberculosis problem does not approach that found among Asian immigrants, Latinos also have a higher prevalence of primary drug resistance. Culture results reported to the Centers for Disease Control show an 11.8% prevalence of drug-resistant tuberculosis among Latinos in comparison to 4.9% for Anglos, 6.1% for blacks and 14.8% for Asians.[33] Clinically, this implies that the initiation of antituberculosis therapy in Latinos should include two drugs in addition to isoniazid.

Depression

The most significant health problems in Latino immigrants lie in the area of mental health. Immigrants entering the United States confront a major adaptation process that manifests in many different ways, especially depression and other symptoms of the posttraumatic stress syndrome.

Depressive symptoms measured by self-report scales have been found to be significantly greater among Mexican-Americans than in Anglos or blacks. The Alameda County (California) study reported the following proportions of respondents scoring above the cut-off for significant symptoms: 14.6% for Anglos, 18.1% for blacks and 28.9% for Latinos.[34] A phone survey in Santa Clara County (California) found similar levels of depressive symptoms in Anglos and English-speaking Latinos, but significantly higher levels of depressive symptoms in Spanish-speaking Latinos.[35] These data suggest that the relative lack of societal integration resulting from low acculturation may account for increased depressive symptoms among Latinos.

The prevalence of lifetime clinical depression among Latinos in the HHANES study was comparable to published rates of lifetime depression in other epidemiologic studies of Anglos or blacks.[36] A self-selected sample of medical outpatients at the UCSF-affiliated clinics showed that the prevalence of lifelong major depression was not significantly different in Spanish-speaking patients (25% of 55) from that in English-speaking patients (18% of 237). Although these data indicate that the relative frequency of clinical depression in Latinos is similar to that of the general population, definite conclusions are premature at this time. Latinos, however, are more likely to present to a primary care physician with somatic complaints when depressed, and, in general, they feel more stigma from using mental health services.

Over the past eight years a large number of Central American immigrants have entered the United States fleeing circumstances of war, economic hardship and outright political persecution. In El Salvador, for example, 20% of the country's population has been displaced either in exile or in existing refugee camps. Immigrants who make it to the United States show a spectrum of mental health problems similar to that observed among US soldiers returning from the Vietnam war. Manifestations of the posttraumatic stress syndrome have resulted in increased episodes of clinical depression, substance abuse, antisocial behavior, family violence and somatization disorder.[37] Awareness of the circumstances that affect these patients and maximum use of available community resources are the initial steps in managing this problem.

Cultural Barriers to Health Care

Language

The language barrier that exists between Spanish-speaking Latinos and English-speaking health care providers presents an obvious impediment to quality health care services. The Robert Wood Johnson Foundation phone survey[5] found that 17% of Latino respondents with emergency room visits in the previous year had been "not at all satisfied with most recent visit" compared with 11% of Anglos and 7% of blacks. In California, the proportion of Latino physicians in 1980 was only 1.7%.[38] Given the plateau in medical school minority admissions in the past decade, it is unlikely the number of Latino physicians will increase significantly in the next 25 years. Thus, the language barrier will be an issue for many physicians who practice in the southwestern states.[39]

The need for a translator during patient visits changes the

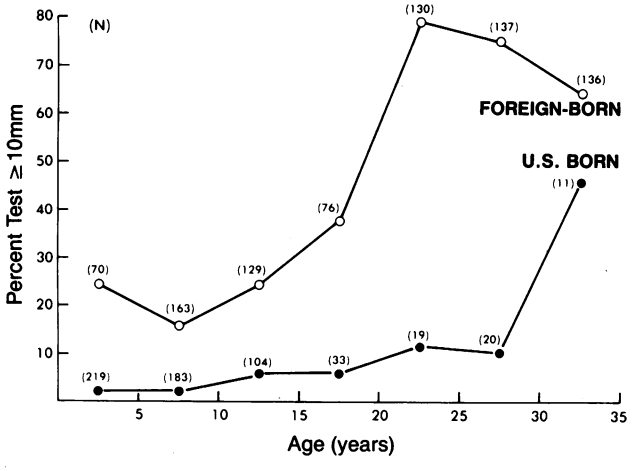

Figure 1.—Proportion of Latinos with positive tuberculin tests by age and birthplace.

nature of the patient-physician interaction. The translator is a third active person creating a triangular interaction. By setting up the physical space in an equilateral way, physicians can maintain direct eye contact with their patients (Figure 2). Translators often act as cultural interpreters and may assist (or hinder) communication with a patient in other ways. Physicians should request a translation of all patient-translator interactions because important details may be omitted in the abbreviated response to a question. Similarly, a translator may respond to a question before the patient has spoken; thus one should request translations of all questions asked of the patient.

Family members are often the only available persons to translate, but frequently they are the least desirable. Adolescents or children are inappropriate translators for adult patients because of the intimate details of the medical history. Adult children of elderly persons may heighten the language barrier by being overprotective and responding directly to questions because they "already know the answers." Trained translators hired by hospitals and clinics with a significant number of non-English-speaking patients may greatly facilitate patient-provider communication and improve the quality of care delivered to this population.

'Familismo'

Latinos tend to have a collective loyalty to the extended family that ranks higher than individual needs. This may be manipulated by the health care provider in an effort to initiate a life-style change or in guaranteeing compliance with a medical regimen. For example, an adult cigarette smoker may find motivation in quitting for his or her children's sake if not for personal health reasons. Similarly, the intact structure of an extended family can provide a buffer system at times of emotional stress. There are also members of the extended family *(compadres* or *comadres)* who usually have no blood relationship, but they are still considered "family."[40]

The family structure in Latinos may also at times hinder appropriate health care delivery. Showing illness or weakness to outsiders—that is physicians—may be a shameful or painful experience. The existence of a male-dominated family hierarchy may increase cultural barriers between Latino patients and non-Latino health care providers. Recognizing and respecting this hierarchy, however, is important, especially when dealing with older patients. Machismo exists to a greater or lesser extent in most Latino men but it may not always carry a negative connotation. The role of protector, strong and in control, is perceived as a positive aspect of machismo and thus expected behavior in Latino men. Women continue to have the dominant role of caretaker and to provide the principal source of health information to the family. Awareness of these cultural scripts may help physicians in their management of Latino patients.

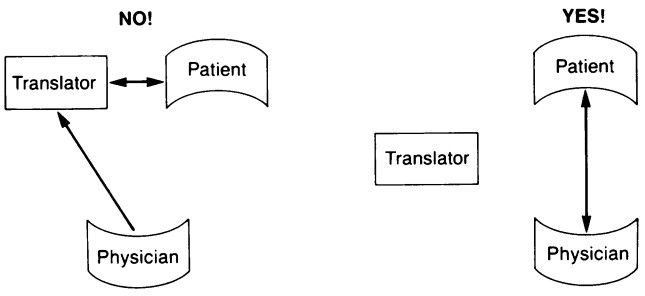

Figure 2.—The diagram depicts the patient-translator-physician triangle. When sitting in an office, do not position the translator next to the patient, but position the translator equidistant from both of you. Whenever asking a question through a translator, engage face-to-face with the patient so that he or she will understand the nonverbals. Whenever a patient answers a question through the translator, ask him or her to address you.

Cultural Expectations of 'El Doctor'

Latino patients view physicians as important authority figures with rank on the level of priests. Although expecting an authoritative expert, Latinos also want a friend they can talk to in their physician. In Spanish, this is best described by the term *personalismo,* which can be loosely translated as "formal friendliness." The impersonal characteristics that frequently accompany modern American medicine are not acceptable in Latino culture. Physicians may be evaluated on the basis of their verbal communication skills rather than their medical knowledge.

In Latino America, the powerful are legitimate to the extent that they respect the *dignidad* ("worthiness") of ordinary citizens. Patients will often establish relationships with physicians based on paternalistic dependence, but these will disintegrate if a tone of *respeto* ("respect") is not maintained. Quesada has traced this relationship to the patron-peon dynamics of prerevolutionary Mexico, and he has called it the dependency-*dignidad* paradox.[41] For example, Latino patients expect a handshake in greeting, and not offering this is considered rude. As patients get to know their physician, some form of physical contact other than the examination is culturally accepted behavior. The polite form of "you" in Spanish *(usted)* should always be used with patients because the informal form *(tu)* is considered impolite and inappropriate to the patient-doctor relationship.

The concept of *personalismo* reflects a general cultural script for Latinos labeled *simpatia* by a group of social psychologists. Triandis and co-workers[42] found that Latinos are more likely than Anglos to expect a high frequency of positive social behavior and a low frequency of negative social behaviors. For example, patient-physician interactions characterized as neutral by Anglo patients may be perceived as negative by Latino patients. Thus, the inattention among non-Latinos to the presence of the *simpatia* script when interacting with Latinos may lead to misunderstandings.

Cultural Reactions of Latino Patients

Latinos tend to express emotions more openly when confronted with a crisis such as illness. In this setting, remaining "calm" is culturally inappropriate and an emotional discharge is expected behavior. Latino women in particular have been characterized as having a lower pain threshold and complaining more frequently and vehemently than persons of other ethnic groups, but there are no data to support this. The higher rate of prescribed psychotropic medications in Latinos may reflect this misconception.

Finally, the process of death and dying in Latinos may elicit different reactions. The standard practice of informing a person of a terminal diagnosis may not always be appropriate. Denial is an effective defense mechanism and should be considered in the Latino cultural context. This is especially the case for older Latinos for whom only palliative therapy can be offered.

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